

LIMITATIONS ON AMOUNT, DURATION AND SCOPE

Services

12a. In compliance with Section 1902(A)54 and Section 1927 of the Social Security Act the Medical Services Division of the Department of Human Services will cover drugs supplied by those manufacturers participating in the drug rebate program with the federal Health Care Financing Agency with the following limitations as defined by the Medical Services Division of the Department of Human Services:

1. Drug Efficacy Study Implementation (DESI) Study drugs as determined by the Food and Drug Administration to be less-than-effective and items that are identical, related, or similar (IRS) will not be allowed for payment.
2. Outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee will not be allowed for payment.
3. Drugs when used for experimental or investigational purposes, for cosmetic purposes, to promote hair growth, or to promote fertility will not be allowed for payment.
4. Drugs when used to promote weight loss with the exception of orlistat when used for morbid obesity will not be allowed for payment.
5. Over-the-counter (OTC) drugs with the exception of drug identified by the Medical Services Division and listed in the Pharmacy Provider Manual will not be allowed for payment.
6. Drugs when used to promote smoking cessation with the exception of Nicorette® gum with a lifetime limitation of 1152 pieces per recipient or a combination of bupropion hydrochloride sustained release tablets and nicotine transdermal patches with a lifetime limitation of two 90 day periods per recipient will not be allowed for payment.
7. Drugs dispensed in quantities of more than a 34 day supply will not be allowed for payment.
8. Drugs identified by the Medical Services division as requiring prior approval and listed in the Pharmacy Provider Manual will not be allowed for payment except in accordance with SSA 1927(d).
9. Viagra is a payable drug under the Medicaid Program, but will be limited to no more than six units per recipient for any thirty day interval.

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Supersedes

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State/Territory: North Dakota

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

- c. Prosthetic devices.  
☒ Provided: ☒ No limitations ☐ With limitations\*
- d. Eyeglasses.  
☒ Provided: ☐ No limitations ☒ With limitations\*
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.
- a. Diagnostic services.  
☒ Provided: ☒ No limitations ☐ With limitations\*
- b. Screening services.  
☒ Provided: ☒ No limitations ☐ With limitations\*
- c. Preventive services.  
☒ Provided: ☐ No limitations ☒ With limitations\*
- d. Rehabilitative services.  
☒ Provided: ☒ No limitations ☐ With limitations\*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.  
☒ Provided: ☒ No limitations ☐ With limitations\*
- b. Skilled nursing facility services.  
☐ Provided: ☐ No limitations ☐ With limitations\*

\*Description provided on attachment.

TN No. 94-018  
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TN No. 87-5

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Effective Date 7/1/94

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## 12d. Replacement Policy - Eyeglasses

Effective September 1, 1997 individuals 21 years of age and older are limited to one pair of eyeglasses no more often than once every two years. Medicaid will not pay for the repair and/or replacement of eyeglasses during that two year period unless the repair or replacement is prior approved as medically necessary by the department's optometric consultant. The same will apply to subsequent eyeglasses in relation to the two-year cycle following receipt of eyeglasses.

Soft contact lenses are not covered under the Medicaid program unless prior approved by the department's optometric consultant.

Hard contact replacement will be covered if the individual wore them when becoming eligible for Medicaid. Initial fitting of hard contacts will also be considered on a prior approval basis when refractive error cannot be corrected with standard eyeglasses.

## 13c. Preventive Services.

The North Dakota Medicaid Program will provide payment if the service is recommended by a physician without prior authorization to a licensed registered dietitian by the state of North Dakota for the following diagnosis or conditions:

1. Diabetes (Insulin/Non-Insulin Dependent and Pregnancy Related)
2. Cardiovascular Conditions including Hyperlipidemia
3. Eating Disorders (Morbid Obesity, Anorexia Nervosa and Bulimia)

All other diagnosis will require prior authorization. The request for prior approval must include a recommendation for the service from a physician and documentation must be present that demonstrates the medical necessity for the service. The medical consultant will review the information and approve or disapprove the service based on a determination that the proposed service will reduce or limit the progression of the particular disease or condition.

All nutritional services will be limited to an initial visit and three follow-up visits. Additional visits may be provided if they are prior authorized by the medical consultant. Additional visits must be recommended by a physician and will be approved if it can be demonstrated that progress is being made in diet control and there is ample evidence that a recipient will continue to need additional visits in order to benefit from the services of a licensed registered dietitian. The number of additional visits may vary based on the individual needs of each recipient.

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State/Territory: North Dakota

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

c. Intermediate care facility services.

☐ Provided: ☐ No limitations ☐ With limitations\*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

☒ Provided: ☒ No limitations ☐ With limitations\*

- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations\*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No limitations ☐ With limitations\*

17. Nurse-midwife services.

☒ Provided: ☒ No limitations ☐ With limitations\*

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations\*

\*Description provided on attachment.

TN No. 87-8  
Supersedes  
TN No. 87-5

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State/Territory: North Dakota

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a) (19) or section 1915(g) of the Act).

X Provided: X With limitations\*

\_\_\_ Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z) (2) (F) of the Act.

\_\_\_ Provided: \_\_\_ With limitations\*

X Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

X Provided: <sup>+</sup> \_\_\_ Additional coverage <sup>++</sup>

- b. Services for any other medical conditions that may complicate pregnancy.

X Provided: <sup>+</sup> \_\_\_ Additional coverage <sup>++</sup> \_\_\_ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: X No limitations \_\_\_ With limitations\*

\_\_\_ Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\*Description provided on attachment.

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TN No. 94-012

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STATE: NORTH DAKOTA

Attachment to Page 7 of  
Attachment 3.1-B

20.a. and b. Includes all services described in attachment 3.1-A.

TRANSMITTAL NO. 93-004  
Date Approved MAY 28 1993  
Effective Date OCT 01 1992  
Supersedes Transmittal New

State/Territory: North Dakota

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

22. Respiratory care services (in accordance with section 1902(e) (9) (A) through (C) of the Act).
- ☐ Provided: ☐ No limitations ☐ With limitations\*
- ☒ Not provided.
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
- ☒ Provided: ☐ No limitations ☒ With limitations\*
- b. Services of Christian Science nurses.
- ☐ Provided: ☐ No limitations ☐ With limitations\*
- c. Care and services provided in Christian Science sanatoria.
- ☐ Provided: ☐ No limitations ☐ With limitations\*
- d. Skilled nursing facility services provided for patients under 21 years of age.
- ☒ Provided: ☒ No limitations ☐ With limitations\*
- e. Emergency hospital services.
- ☒ Provided: ☒ No limitations ☐ With limitations\*
- f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
- ☐ Provided: ☐ No limitations ☐ With limitations\*

State: North Dakota

Attachment to Page 8 of  
Attachment 3.1-B

23.a Transportation.

Refer to Attachment 3.1-D for transportation limitations.

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State/Territory: North Dakota

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

☐ Provided ☒ Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☐ Provided: ☐ State Approved (Not Physician) Service Plan Allowed

☐ Services Outside the Home Also Allowed

☐ Limitations Described on Attachment

☒ Not provided.

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